

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on January 29, 2004.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The hot and cold pack therapy (97010), electric stimulation unattended (97014), manual therapeutic techniques (97140) and 2 units of therapeutic exercises (97110) for 08-20-03 through 08-29-03 **were** found to be medically necessary. The hot/cold pack therapy (97110), electric stimulation (97014), ultrasound (97035), therapeutic exercises (97110), massage (97124), ultrasound (97035) and manual therapeutic techniques (97140) for dos 08-06-03 through 08-18-03, and 09-02-03 through 10-13-03 **were not** found to be medically necessary. Also, the ultrasound (97035) and massage (97124) and therapeutic exercises in excess of the 2 units approved for 08-20-03 through 08-29-03 **were not** found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this Order. This Order is applicable to dates of service 08-20-03 through 08-29-03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 23rd day of April 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division
PR/pr

NOTICE OF INDEPENDENT REVIEW DECISION

Date: April 14, 2004

MDR Tracking #: M5-04-1536-01

IRO Certificate #: 5242

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a Chiropractic reviewer who has an ADL certification. The reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

The claimant was injured on ___ lifting a bag weighing 150-200 pounds. Following this injury, complaints involved the neck, shoulders and lower back. A cervical MRI revealed a protrusion at C4/5 with some impingement on the left side of the spinal cord. A lumbar MRI revealed a minimal annular bulge at L2/3. EMG of the lower extremity performed on 6/25/03 showed no evidence of radiculopathy. There was no documentation available regarding an upper extremity EMG; however, ___ notes in his 2/2/04 letter that there was a positive EMG confirming cervical radiculopathy. No specifics are given as to the level of involvement. The claimant had an IME with ___ on 7/28/03 who felt the cervical spine pain and radiculopathy were a result of the compensable work injury and recommended additional diagnostic testing to include a cervical myelogram and CT, evaluation with a neurologist with progression to a work conditioning program and work hardening program after treatment with the neurologist. Per the IME report, the claimant had fairly regular chiropractic treatment from 10/25/02 to 5/3/03. He also felt the lumbar injury was not documented as related to the ___ work injury. He also felt continued chiropractic treatment was not necessary due to the lack of any significant relief with the considerable chiropractic treatment all ready having been performed. ___ performed a sacroiliac joint injection on 10/21/03 and recommended joint mobilization with the chiropractor following this procedure. On epidural steroid injection was also documented as being performed by ___ on 12/16/03 with recommendations for a work conditioning program, a second epidural steroid injection and continued therapy. The claimant was also evaluated by ___, neurologist, on 8/19/03 who recommended continued conservative care and range of motion exercises.

Requested Service(s)

Hot and cold pack therapy, electric stimulation unattended, ultrasound, therapeutic exercises, massage therapy, manual therapeutic techniques from 8/6/03 through 10/13/03.

Decision

I agree with the insurance carrier that not all of the services provided were medically necessary. All treatments provided by the chiropractic on the following dates of service were not medically necessary: 8/6/03, 8/8/03, 8/11/03, 8/13/03, 8/14/03, and 8/18/03. Three passive modalities and 2 units of therapeutic exercise were medically necessary on 8/20/03, 8/22/03, 8/25/03, 8/27/03 and 8/29/03. Ultrasound and hot/cold packs provide similar thermal type therapeutic benefits, therefore, both of these services on the same date are not medically necessary. Manual therapy techniques and massage also encompass the same types of procedures and are not medically necessary on the same dates of service. Electric muscle stimulation would be medically necessary. Therapeutic exercise was medically necessary, but only 2 units not 4 units. Therefore, on the previously noted dates, 97010, 97014, 97140, and 2 units of 97110 were medically necessary. All treatments on the following dates of services were not medically necessary: 9/2/03, 9/3/03, 9/5/03, 9/8/03, 9/10/03, 9/12/03, 9/15/03, 10/2/03, 10/3/03, 10/6/03, 10/8/03, 10/10/03 and 10/13/03.

Rationale/Basis for Decision

The claimant had extensive chiropractic treatment without resolution or documented subjective benefit or functional gain from October 2002 through July 2003. After being evaluated by ___, neurologist, on 8/19/03, nonspecific recommendations were made for continued conservative care and range of motion exercises. The doctor recommended a follow up in 10 days. Therefore, in this reviewer's opinion given the provided medical information no chiropractic treatment was documented as medically necessary until after ___ recommendations on 8/19/03. Only chiropractic treatment provided from 8/20/03 through 8/29/03 including the previous noted 3 passive modalities and 2 units of therapeutic exercise was medically necessary. Chiropractic treatment beyond this date was not medically necessary because the neurologist was to follow up with the claimant after 10 days of conservative treatment. No follow up was documented. No additional recommendations for rehabilitation came from the neurologist. The rationale for only 3 passive modalities was due to the duplication of therapeutic benefits with 97010 and 97035, as well as with 97140 and 97124. The reason for the reduction in therapeutic exercise units was due to the neurologist recommendation for range of motion exercises. Range of motion exercises can be performed at home and do not require 1 hour of one on one attention. Therefore, 2 units or 30 minutes of 97110 would have been appropriate. None of the treatment provided from 9/2/03 through 10/13/03 was considered medically necessary because the treating doctor's rationale for this ongoing treatment was based on the recommendations from the IME doctor, ___, neurologist and ___ who provided injections. The IME doctor felt no further chiropractic treatment was necessary. He did feel that a work conditioning program and work hardening program would be appropriate, but the treatment being reviewed was not documented as a work conditioning program or work hardening program. There was a recommendation for a work hardening program made during a psychological evaluation on 8/28/03. However, the treatment was heavily passive and was not documented as a work conditioning program or work hardening program per the TWCC guidelines. The injections were performed on 10/21/03 and 12/16/03 which did have recommendations for therapy afterwards, but these treatments were beyond the dates of service being reviewed in this case.